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PROVIDENCE MEDICAL ASSOCIATION

Address of the President

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PROVIDENCE, RHODE ISLAND

Fellow members of the District Society. This is a year in which so much has happened and so much lies just below the horizon of the immediate future, about to happen, that the problem of your retiring executive officer in presenting the customary annual address is to select and condense and to present as briefly and clearly as possible the most important phases of what has occurred, what is occurring and what is about to take place. The matter of greatest interest to us as physicians is the attempted change in the application of medical care to the American people—especially as it applies to that portion of the people which resides in Providence. Nationally our concern is with the occurrences and influences which led up to the National Health Conference in July, the recommendations of the Conference and the reaction of our House of Delegates expressed in the resolutions adopted at the Chicago meeting in September. These things have been discussed before you and with them you are quite familiar. Their relation to local affairs, however, to the medical care and general health of the people of Providence is a matter which must engage our attention. Let us therefore consider the need, if any, of a change in the method of supplying medical care to the people of our city and the qualifications of our medical society, with the recent extension of its activities, to meet the challenge. Let us seek to answer the question "What can we do about it?"

The clear and concise summary of what has happened nationally, presented to this Association at its December meeting by Mr. Myron Weiss and the address by Dr. Rock Sleyster before the State Society three days ago, make a detailed survey superfluous. Certain facts, however, will bear re-emphasis. In 1929 Dr. Wilbur's committee on the costs of medical care found that all was not well and made recommendations that are quite similar

to those advanced by the Technical Committee of the National Health Conference. The economic depression which followed 1929 made bad matters considerably worse and there has been on the part of various groups in the population a growing demand that something be done. The pattern of that something is definitely foreshadowed by the Social Security Act of 1935 by which public health is made a part of public welfare in general and the responsibility for constructive planning is placed in the hands of welfare workers, sociologists and their colleagues—rather than the medical profession. Such a plan, as Mr. Weiss pointed out, makes doctor and nurse mere technicians, "non-commissioned officers and buck privates"—without a part in the general direction of their work.

The summary of medical opinion gathered by the American Foundation and published as "Expert Testimony out of Court" showed that a majority of the doctors who contributed believed a great improvement in the medical situation to be needed. A committee of physicians formed itself and formulated "Principles and Proposals," which received unfortunate publicity and were rejected by the American Medical Association.

Following the completion of the National Health Survey which showed a large number of people in the country unable to obtain adequate medical care the National Health Conference was called and its deliberations were conducted to a great extent, it appears, without real consideration of the extensive studies which had been carried on by the American Medical Association or consultation with its experts. However that may be, we know that at the special meeting of the House of Delegates in September, the American Medical Association went a long way toward accepting most, not all, of the recommendations.

This action of the House of Delegates, formally approved by our State Society, definitely disapproves of compulsory health insurance, but with this important exception it registers qualified approval of practically all the recommendations, and reverses its attitude regarding the much-criticised "Principles and Proposals" as the following tables show:

Presented before the Providence Medical Association at the Annual Meeting, January 9, 1939.

TABLE I

P. & P.
Extension of Public Health Services proposed (7) and establishment of *Federal Department of Health* advocated (9).

National Health Conference
I. Expansion of Public Health Services. Local organization stressed. Maternal and child welfare included.

House of Delegates
Approved in general. Treatment of disease excluded where private practice is available. Cooperation of A.M.A. promised. *Federal Department of Health* advocated.

TABLE II

P. & P.
Public Funds for hospitals including laboratory, diagnostic and consultation services proposed (5). *Utilization* of private institutions urged (6).

National Health Conference
II. Expansion of hospital facilities. Federal grants for new hospitals when needed and enlargements of existing hospitals. Use of non-government hospitals included with federal support for care of indigent.

House of Delegates
Approved where need exists. Use and support of existing hospitals stressed. Stability and efficiency of existing church and voluntary hospitals thus secured.

TABLE III

P. & P.
"An immediate problem is provision of adequate medical care for the medically indigent, the cost to be met from public funds (*local* and/or *state* and/or *federal*)." Proposal No. 2.

National Health Conference
III. Federal support to states for care of needy. *Medical and allied professions and institutions* to participate in this care.

House of Delegates
Fact that federal support may at times be needed is recognized. *Local* government tax funds to be the basis of care of needy with *state* aid if need cannot be met locally and *federal* aid if state cannot meet the need.

TABLE IV

P. & P.
No proposal of a comprehensive general health program reaching above the level of the medically indigent. "Health insurance alone does not offer a satisfactory solution."

National Health Conference
IV. A program of general public medical care (like public education) supported by *tax funds* (including federal funds) or *health insurance* (compulsory).

House of Delegates
No direct comment on this general proposal. Compulsory health insurance disapproved (bureaucracy, political manipulation). Group hospitalization and voluntary indemnity insurance approved.

What does all this mean? It means that as a profession we have recognized that the great public demand for a change, even though fostered by unfair propaganda and a gross misrepresentation of the attitude of the organized profession, must be met and a change, such as will not result in public harm, must and will be considered. It means that what the press delighted to call a "schism" in medical ranks—the difference of opinion regarding the Principles and Proposals—no longer exists. It means that the American Medical Association is willing to take liberal and constructive action and, recognizing that changes of a drastic and harmful nature are likely to be forced upon it, is ready to meet the issue and to assume its full share of

responsibility in the hope of some definite improvement in conditions and a minimum of harm.

What, then, does all this mean to us here in Providence? What are our medical needs and what is our ability to cope with them?

We can form some opinion as to medical needs by a study of the results of the survey made by our Association as a part of the American Medical Association's National Survey. This report was summarized before this Association by Dr. Messenger, Chairman of our committee in charge of the survey. Some of the pertinent facts brought out are as follows:—The number of doctors is adequate, hospitals and clinic facilities are adequate, health services in schools and colleges are

adequate for this community. The indigent of the city of Providence are well cared for, although neighboring communities are not in many instances doing their parts so that in practically all cases in which an indigent person could not get medical care, that person was from outside Providence and failed to get support from his own community. The doctors of Providence are bearing their full share of this burden, for a conservative estimate shows that they have been caring for approximately ten per cent of the population free of charge. On the whole the survey showed that, except for dental care, the indigent are well provided for.

The problem of the low income group, however, is another matter. As brought out by the report and as every practitioner knows, it is the self-respecting people who will not ask for charity to whom illness is the greatest burden and who receive by far the poorest care. Although the earlier survey by the committee headed by Dr. DeWolf in 1936 showed that people in this group do not fail to get care, that committee recognized that many of them had to obtain it by dropping to the level of receiving charity when their funds were gone. Furthermore, the increasingly complicated and expensive procedures that are needed for modern medical diagnosis and treatment are so often beyond their reach that the care they get is at times anything but adequate. Here lies the real need, the supplying of up to date complete medical services to the low income group. It is for this that the great popular demand exists. This need is present in this community and in all communities. It is to meet this need that compulsory health insurance is advocated and, because of the insistence of this need, may be forced upon us with all its disadvantages if there is nothing else to offer. Certainly compulsory insurance is not desirable—but as certainly some methods of prepayment by which people can be protected from catastrophic illness must be instituted.

Knowing this background and this need let us turn to examine the status of our own Society to see how capable we may be of doing anything about the matter. The past year has seen the fruition of many earnest efforts. The enlarged standing committee, now a really representative body, has put in many hours of earnest work, as have the other important committees. The committee on the American Medical Association survey, the committee on tuberculosis, the publicity committee with its radio

program and other educational work and so forth—with all these you are familiar. A great deal has been accomplished and we are only just beginning. Without our executive secretary, Mr. Farrell, practically all this would have been impossible. To Dr. William Streker and to Dr. Gormly, Dr. Chase, Dr. Buffum and many other earnest workers and to our whole membership for its loyal support, must go the credit for these great advances. Our year has been a good one—but I repeat—it is only a beginning. We have begun to put our affairs on an efficient basis and to take our place as a real force for good in our community. We have developed the mechanism for doing things—What more shall we do?

The answer is—the low income group—to that we must give our attention. Federal interference and compulsory insurance are almost upon us. Can we so put our house in order that they will not be considered needed?

Group hospitalization is being studied by our State Society in conjunction with the hospitals and is apparently about to arrive. This is the first step.

In California the State Society is developing a system of voluntary insurance to cover medical services. In Washington, D. C., the district society is attempting to do the same thing. In New York "The step to legalize prepayment insurance is being advocated by the State Society . . . as an alternative to State-controlled compulsory health insurance. . . ." Elsewhere throughout the country similar plans are being studied. The American Medical Association has investigated and approved many such plans.

Ladies and gentlemen I suggest to you that the only way open for us to offset the menace of federal interference and compulsory health insurance is to attempt to meet it halfway. I therefore propose to you that this Association, realizing the need for aid to the low income group, begin forthwith a study of the possibility of the formation of a non-profit health insurance plan organized and operated by our society. Such a plan, if successful, may be extended to cover so great a proportion of those in our community who need it, that there will be no occasion or excuse for the intrusion of a government plan of compulsory insurance or other supervision of medical practice, an intrusion which would put our people and ourselves under a complicated bureaucratic control subject to political manipulation.

Our year has been a good one. Our affairs are in order. Our members are meeting the responsibilities of their work with earnestness and interest. Our executive secretary is keeping the whole thing coordinated and running smoothly, performing his function with vigor and an able enthusiasm which helps us all. It has been a privilege to have a part in this work. Few district societies are better able than we to cope with the urgent problem, an attempt at the solution of which I have just suggested to you. It will be a pleasure, under the able leadership that is to follow, with you all to help in its solution.

THE RELATION OF THE HOUSEHOLD DUSTS TO ASTHMA IN CHILDHOOD

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Household dust is now recognized as an important exciting cause of asthma. The good results obtained by simple methods of study and treatment justify further attention to this important allergic problem. We are presenting, therefore, a series of 101 children with bronchial asthma, in whom we have investigated the factor of household dust sensitization.

The discovery of a specific allergen in house dust was made in 1918 and published in 1922 by Cooke.¹ The patient whose case led to this discovery was a young man who had had intractable asthma for fourteen years and whose asthma dramatically disappeared when he arrived at military camp only to reappear whenever he returned to his home. Skin tests with the usual inhalants were all negative but intracutaneous tests with dust extracts gave positive reactions. Cooke then investigated other cases of asthma which were hitherto undiagnosed, finding that some gave positive skin tests to dust extracts and that their clinical picture could be explained on the basis of house dust sensitization. Further studies led him to the conclusion that sensitivity to house dust is due to some unknown but specific allergen present therein. He felt that the active principle in dust was not due to the presence of the usual inhalants, such as feathers, rabbit hair or orris root powder, which are apt to be present in house dust.

In 1926 Peshkin,² investigating the specific causes of 100 cases of asthma in children, found that 46 percent gave positive dust reactions. Rabbit hair was the only substance giving a higher incidence of positive reactions. In many of Peshkin's cases dust was apparently the sole exciting cause; in others it was responsible for the symptoms to a varying degree. He believed that the dust allergen was specific and different from other known inhalants.

In 1927, Feinberg³ called attention to the difference between hypersensitivity to dust, which is a true allergic phenomenon, and the irritation which may be produced on the nasal mucosa by dust inhalation.

In 1927 Rowe⁴ was of the opinion that persons allergic to dust are in reality allergic to the inhalants which are present in the furnishings in the home, as these furnishings are constantly giving rise to dust. Rowe made the observation that not all dusts are equally active and that no one dust extract produced reactions in all his dust positive cases. Therefore, for testing, Rowe advised the use of an extract derived from many sources.

An interesting study on the nature of the house dust allergen was made by Cohen⁵ in 1935. By a series of ingenious experiments in which he neutralized samples of serum from dust-positive reactors with various extracts and then studied these serum samples by means of the passive transfer test, he concluded that the active principle in house dust is formed during the aging process of cotton lintens, and probably also in the aging of other substances, such as feathers or kapok. Cohen also demonstrated that the active principle is not a mould. In 1935 Cazort⁶ repeated Cohen's experiments with similar results.

In 1936 Pratt⁷ published his study on house dust sensitivity in childhood asthma. He was the first to study dust sensitization in children. Using the intracutaneous test on seventy-one children with perennial asthma, Pratt found 55 or 79 percent with skin reactions positive to dust and in twenty of these he was able to transfer the reaction to their parent's arm. He found no correlation between the dust reactions and those of other inhalants, pollens or foods. Thus his series supports Cooke's contention that the dust allergen is independent of other known inhalant allergens.

From the Pediatric Allergy Clinic, Rhode Island Hospital. Read before the Providence Medical Association, June 6, 1938.

A most instructive piece of work on the kapok fiber was done in 1936 by Wagner and Rackemann,⁸ when they showed the striking increase in allergenic activity of old kapok as compared to new.

In 1937 Walzer,⁹ in a series of 151 atopic cases observed over a period of 8 years, found that in every instance in which a dust reaction could be transferred reagins could also be demonstrated for one or more other such dust-producing inhalants as cat, dog and rabbit dander, feathers, wool and kapok. When dust reagins were absent in a serum no positive transfer could be demonstrated to any of the above dust-producing inhalants.

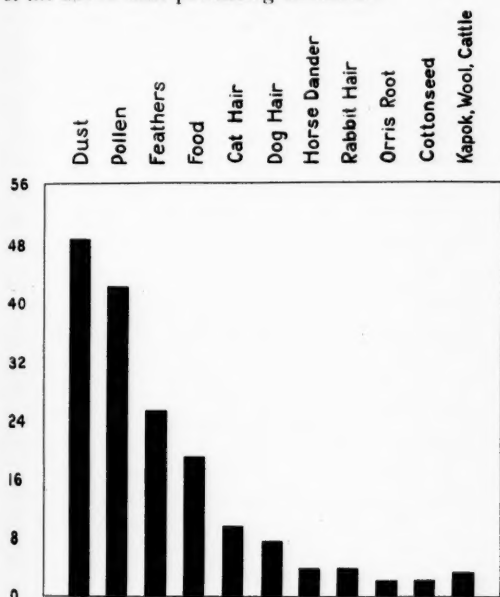


Chart 1. - Number of patients giving positive skin reactions to dust and other allergens.

Choice of Patients, Testing Material and Technique

In this series of 101 children with asthma the patients were entirely unselected. Eleven others were excluded because the testing was incomplete; six had moved and could not be followed. No patient was omitted because of incomplete treatment or lack of coöperation. Seventy-eight children had perennial asthma; twenty-three had seasonal asthma. The youngest patient was eight months old on admission, the oldest twelve years. The age of onset of the asthmatic attacks ranged from two months to ten and a half years, with an average age

of onset of four and eight-tenths years. Seventy-two patients were from the Rhode Island Hospital Pediatric Allergy Clinic; twenty-nine were from private practice. All patients were under observation for more than one year; many had been observed as long as five years.

In this series of cases, the scratch test was employed almost exclusively. Although the intracutaneous test is more sensitive, it is more likely to give false positive readings. The high potency of the material now available for scratch testing makes this method of skin testing satisfactory for routine work.

We used the following testing material:

1. *Autogenous Dust.* This was usually obtained from the patient's pillow, mattress, bedroom and living room floors. Tests were made by placing a sample of each dust soaked for a few minutes in saline or 14% alcohol on a scratch on the volar surface of the forearm. Out of seventy-five children tested, nineteen reacted to an autogenous dust.

2. *Stock Dust.* This was used as prepared by the commercial houses. Of the 101 patients tested with stock dust, 45 gave positive reactions.

Reactions ranged from + to +++++. A + reaction is one in which there is an area of erythema definitely larger than the control. Usually the wheal is also somewhat larger.

Relation Between Positive Reaction to House Dust and to Other Inhalants and Foods

Analyzing our own cases to demonstrate the relationship between dust reactions and reactions to other known inhalants we found that of thirty-four cases who reacted to one or more of the animal inhalants, twenty-five or 73% were dust positive, nine or 27% were dust negative. Furthermore, the twenty-five patients who were dust positive gave markedly strong reactions to the animal inhalants while the nine who were dust negative gave weak reactions to these inhalants. This relationship between the reactions to house dust and the reactions to animal inhalants would be expected, in view of Walzer's recent work. (Table 1.)

Making a similar analysis of the patients reacting to foods, we found that food reactions are independent of dust reactions. Of seventeen patients reacting to food, nine were dust positive and eight were dust-negative; this being almost equal distribution. (Table 2.)

Of forty-two patients reacting to pollens, twenty-five were dust positive and seventeen dust negative, indicating that pollen reactions also are probably independent of dust reactions.

TABLE 1
Relation of Positive Animal Inhalant
Tests to House Dust Reactions
House Dust Positive

Case	Feathers	Dog	Cat	Horse	Rabbit	Cattle
R. A.	+++
R. A.	+++
H. B.	+++
E. B.	+++
J. C.	+++	++
D. C.	++
R. C.	++
B. C.	++
R. D.	++
C. D.	++	+++	++
A. L.	+++	+	++
D. M.	++	++
D. M.	++	++
E. M.	+++
V. M.	++
J. M.	++	+++	+++
G. M.	+	++
A. P.	+++
G. S.	++	+++	+
E. S.	++
E. T.	++	++
E. T.	++
R. T.	++	+
J. V.	+++	++	++	+	+	+++
A. W.	++

House Dust Negative

Case	Feathers	Dog	Cat	Horse	Rabbit	Cattle
E. D.	++
R. F.	++
E. F.	+	+
H. L.	+
M. P.	+
J. S.	++
L. T.	++
H. B.	+
H. W.	+

In our series of 101 cases, we found eight in which household dusts were definitely proved to be a major exciting cause of asthma. This was shown by the fact that five were immediately improved by a general preparation of the house, two by changing the mattress and one by removal of a stuffed sofa. In these cases the improvement was so marked and striking that there is no reasonable doubt that the cause of the symptoms was found. Although we felt that a great many more were clearly household dust cases, this group of proved cases is of greater interest. All of the eight proved cases had frequent wheezing, not limited to definite attacks but occurring at odd times and sometimes of very brief duration. This frequent wheezing without relation to colds or definite attacks is suggestive of an inhalant allergen and is worth noting. Another frequent symptom was rhinitis. In the

records of four of these patients stuffiness of the nose with pale turbinates appears as a prominent feature. With our eight proved cases the lack of seasonal incidence was interesting. Four had no noticeable increase or decrease in symptoms at any time of the year. One was worse in winter. Two were slightly worse in the fall, but these both had positive skin tests to ragweed. One was worse in the summer. This was obviously due to a mattress in the summer house. These cases conform to the generally accepted idea that household dust sensitivity ordinarily causes symptoms which are the same throughout the year or worse in the cold weather.

TABLE 2
Relation of Positive Food Tests
to House Dust Reaction
House Dust Positive

Case	Milk	Egg	Wheat	Sweet Potato	Potato	Corn	Spinach	Tomato	Pea	Beet	Strawberry	Beef
R. B.	++	+++
M. G.
H. M.	+
D. M.	++	+	++	++
E. J.	+	++
J. V.	++++
C. D.	+
J. M.	++++	+
R. X.	+	+	+

House Dust Negative

Case	Milk	Egg	Wheat	Corn	Spinach	Tomato	Strawberry	Plum	Beef	Lamb	Salmon
D. A.
H. B.	++
F. C.	+++
S. G.	++
H. H.	++
L. T.	+++	+++	+++	+++
H. W.	++	+	++	+++	+++
V. S.	++++

In studying our cases it is evident that, in the severe cases, dusts are an extremely important cause. Among our 101 cases, thirteen were classified as severe. Of these, eleven gave positive housedust skin tests and four were proved cases of clinical sensitivity to household dusts. Of the three cases which were definitely the most severe of all, two were proved and the other was a probable household dust case. The predominance of household dust sensitivity in these cases suggests that household dusts are the common exciting factor in severe asthma. Probably this sensitization is just as common in milder cases but is less easily recognized when accompanied by other sensitivities.

Diagnosis

The diagnosis of household dust sensitivity is made by history, testing and experimentation with the environment. The importance of the history has been emphasized by Rackemann¹⁰ and others. A careful history, with dates, activities and occupations of adults in the family, and presence of animals, may indicate other sensitivities. Household dust sensitivity may be suggested by the persistence of symptoms at home and the relief on moving away or visiting for shorter periods. Changes in household furnishings, especially bedding and stuffed furniture, may bring a striking improvement. Exacerbations during week ends at home or after a weekly house cleaning are not uncommon.

An examination of the house is an absolute essential in treating any case of asthma unless some sensitivity, such as ragweed, is evidently the only important cause. An inspection of the house suggests such objects as pillows, mattresses, cushions, stuffed furniture, stuffed toys and rugs, which need to be removed or at least considered for skin testing and experimentation. Of especial importance in our group were feather pillows and cushions, kapok mattresses and stuffed furniture. Rugs are probably more important as collectors than as producers of dust.

In making a diagnosis of household dust sensitivity, the tests are of greatest value in suggesting the diagnosis, not in proving it. Table 3 shows the positive skin tests on our eight proved household dust cases.

TABLE 3
Tests on Proved Household Dust Cases

Case	Stock Dust	Own Dust	Feathers	Cat	Dog	Horse	Rabbit	Orris	Egg	Spinach	Ragweed
C.A.	++++
E.B.	+++	++
M.D.	++++
H.M.	++	+++
J.V.	+++	++++	++	++	+	+	++	++++
E.B.	++	++++
J.M.	+	+++	++	++	++	+	+
M.S.	+	+	++

In household dust sensitivity, stock house dust skin tests are usually positive as well as feathers and other animal inhalants. During the last year, due to improved testing materials, we have had very many more positive reactions. Results from tests to the patient's own dusts have been variable, possibly due to our inability to get a concentrated extract.

The final diagnosis of household dust sensitivity is made by experimentation. In our group the imperfect preparation of the house was usually carried on simultaneously with other treatment so that a definite proof of the diagnosis was lacking. When possible the elimination of the suspected furnishings or the preparation of the whole house should be sudden and complete, without other treatment at that time.

Treatment

Certain aspects of the treatment in household dust sensitivity can be best shown by describing the case histories of three patients. These cases were the most severe of all; two were proved household dust cases and the third a probable one. They are used as illustrations because they typify the reactions of some patients to treatment. We consider the treatment of the housedust sensitivity; the treatment of the child as a whole is obviously important but is not mentioned in this discussion.

Jack, a private patient, is now fourteen years old. He had facial eczema in infancy. Asthma began during his second year. When seen during his third year he was wheezing practically all the time and nearly half the time was having severe asthma, only partly controlled by adrenalin which his mother injected. He was slightly worse in winter than in summer. His first testing gave reactions to four foods and dog dander. During the next five years the foods to which he reacted were left out of his diet, the dog sent away, his bedroom was kept very clean, but he used a kapok pillow and a kapok mattress. He had much medication and sometimes would need adrenalin two or three times a day for a month. At this time he was wheezing more than half the time and was an underdeveloped, undernourished, barrel-chested, pale and unhappy looking child. His positive tests now were dog, horse, cat, one food and ragweed. When he was seven years of age the house was thoroughly prepared. He had a special pillow, a horse hair mattress covered tightly with dust proof material. All unwashable cloth and stuffing material was, as far as possible, removed from the house. No unwashable bedding or rugs and no stuffed furniture was used. Although we had done no housedust testing, everything in the house was thought of in terms of dust producing animal and vegetable fabrics. The floors were dusted daily with a wet mop and small washable rugs were shaken out of the windows. After this he made a striking improvement and a further gradual im-

provement has continued. He received 30 injections of dog dander, 10 injections of horse dander and 30 injections of ragweed, but has had no treatment for the last eighteen months. During the last year he has been almost well. He had moderate wheezing twice, once for forty-eight hours after playing in the woods and once for twelve hours after a party. He has also very slight wheezing for a few minutes several times. His skin tests now are about the same and include a positive stock house dust reaction.

The treatment of this case was unusually thorough. The mother was very intelligent and faithful. Through the help of a physician relative, the patient received a great many injections without much inconvenience. Although at puberty there is frequently a definite tendency to spontaneous recovery, the effective factors in treatment in this case seem to have been the preparing of the house and the injections of animal danders and ragweed.

The second of the three patients, Edward, has a history so nearly identical with patient A that it is unnecessary to mention it further: Edward has had only one slight attack in the last 18 months.

The third patient, Lucy, although her course was at the start very similar, has not done well. Lucy is now 14 years old. One parent had hay fever. The patient had eczema on her face and body for the first 4 years. Her asthma started in June at seven months of age. Her positive tests at this time were milk and eggs. Dietary control kept her fairly well. During two summers she had practically no trouble, but during the fall and winter and spring she had a little wheezing most of the time and bad attacks with colds. In 1932 she had more asthma for three months following measles. At this time her positive tests were dog, horse and cat. Housedust tests were negative. She looked badly, had a barrel chest and wheezed some nearly every day. During these last ten years she has had very little treatment. Except for using a special pillow, no house preparation was possible. In 1936 her positive tests were dog, cat and stock house dust. There were dogs in the yard and garage, but no cats. In 1937 after 12 injections of dog dander she was considerably better and went a month without asthma. In 1938 she is wheezing a little every day and still looks badly. Her house still contains many dust producing objects including stuffed furniture and rugs.

The favorable results obtained in the first two of the cases mentioned and similar experiences in many other less striking instances indicate that the proper preparation of the home is the most effective method in the treatment of house dust asthma. Our plan of preparation of the house is as follows:—We test the patient with materials and dusts from his own home, including pillow and mattress stuffing and dust from the bed room, living room and stuffed furniture. These tests are so frequently negative, probably because of failure to get a sufficiently concentrated solution of the allergen, that we use a routine procedure in eliminating dusts. If any tests are positive, especial attention is given to objects indicated by the tests. The patient's parent is given typed directions. The feather or kapok pillow used by the patient is eliminated entirely or covered with dust proof material. The kapok or cotton mattress is also banished or covered. Usually the clinic patients covered the mattress with oil cloth which was sewed to completely enclose it. Pillows and mattresses in other rooms are not included in the first routine preparation but unwashable rugs and stuffed furniture are not allowed in the house. Later this house is visited by one of us, or in the case of a clinic patient, by the social worker. At this visit the results of the written directions are checked and the house is inspected for other unwashable animal and vegetable fabrics such as quilts and draperies.

We have found that the parents of the clinic patients will usually prepare the homes in a satisfactory manner if we take pains to explain the situation to them and keep after them. With the private patients in larger houses we have had much more difficulty. In these latter cases, the testing with individual dusts has been helpful, both in selecting articles for elimination and also in interesting the parents in the whole problem.

Our experience with desensitization to house dust has been too small to allow of any definite conclusions. Several cases have been worse after the first two or three injections and the treatment has then been discontinued. Several have been better, but not to any striking degree. The impression is that these patients do not benefit as much by house dust injections as other asthma patients do with the proper therapy.

Patients who are also skin sensitive to an animal dander have apparently been greatly helped by injections of that allergen. This treatment has seemed preferable to the house dust injections. Although vaccine therapy does not properly come under the heading of specific desensitization, it may not be out of order to mention here that most of our patients received vaccines at some time. In general these injections were evidently beneficial.

Results

In tabulating the results of the entire group we divided the cases into four classes according to their condition during this last year.

1. No symptoms for one year. This meant absolutely no wheezing and no cough to amount to anything.
2. Much improved. These patients may have had two or three slight wheezing spells during the year but have lived normal lives, missed no school on account of asthma, and were for all practical purposes well children.
3. Improved. These children were markedly better, at least 50% improved.
4. Not improved. In this group the improvement, if any, was not striking enough to be considered important.

In the whole group of 101 patients the results were as listed below.

No symptoms for one year.....	22
Much improved	39
Improved	27
Not improved	13
	<hr/> 101

Adding together the first and second group, we find that 61 of our cases were either entirely relieved or much improved during the last year. An additional 27 were definitely helped and only 13 were not decidedly helped. We realize that it would be much more interesting if we could report after a longer period and hope to be able to do so later on the same cases.

Discussion

Although it is uncertain just what are the substances or the substance in house dust which cause the symptoms in our asthmatic children, it is necessary to have some concept as a working basis. We consider that the active principle of house dust is a mixture of dusts from the skin, hair and feathers of animals, and from the fibres of vegetable materials; and that some of these materials, especially feathers, cotton and kapok become much more allergenic as they degenerate with age.

In skin testing, we have many more positive reactions with our improved materials. In this series of patients, the greater number have had no testing during the last year. Thus our total number of positive tests is small according to our present standards. In table 4, the 5th, 6th and 7th patients were tested recently and show the positive reactions to animal inhalants that we now expect to find.

Our patients were consecutive unselected patients, our treatment often fell far short of the thoroughness desired, and some patients had no effective treatment at all. Our impression is that the injections, both specific and non-specific, were valuable, but that in many cases the preparation of the house was the most important factor.

Conclusions

1. Of 101 unselected cases of asthma in children, forty-five gave positive scratch tests to a stock house dust preparation. Of these fifteen also reacted to their own house dust. Four additional patients reacted to dusts from their own homes but not to stock dust.
2. Patients who react to animal inhalants usually react also to house dust. This fits in with the conception that the animal danders, with other materials such as old kapok and cotton, form the active principle of house dust.
3. It is evident that in most of our severe cases the household dusts are an exciting cause of symptoms. Probably in the milder cases this factor is less obvious but no less important.
4. The proper preparation of the home is an important part of the treatment of most asthmatic children.

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THE RHODE ISLAND MEDICAL JOURNAL

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EDITORIAL

At the meeting of November 21, 1935, the Council voted that "all funds accruing to the Rhode Island Medical Society shall be deposited with the Treasurer, and that all disbursements of funds shall be made by the Treasurer after approval by the officer or committee incurring the indebtedness." The effect upon the RHODE ISLAND MEDICAL JOURNAL of this decision was to transfer the financial control from the Publication Committee to the Treasurer.

At the meeting of September 16, 1937, the Managing Editor reported to the Council that he had resigned his appointment, that in his opinion the present arrangement is impracticable, and recommended that one of the following solutions be adopted:—

"1. To discontinue publication of the Transactions of the Society. After an unbroken record of seventy-eight years this does not seem desirable. The Society would face increased lack of interest, the Library would lose the many exchanges and the books which are reviewed.

"2. To arrange with the *New England Journal of Medicine* for publication of the Transactions of the Society.

"3. To return to the Business Manager control of the JOURNAL, financial and other.

"4. To entrust financial and editorial control of the JOURNAL to the Committee on Publication."

In case the last plan should be adopted, the Managing Editor recommended:—

"1. That members of the editorial and business board of the JOURNAL be not eligible for membership on the Committee on Publication.

"2. That the Business Manager make a monthly report on the condition of the JOURNAL to the Publication Committee.

"3. That the Publication Committee submit to the Council an annual report on the financial condition of the JOURNAL.

"4. That the Council appropriate a sum equivalent to the price of one subscription to the JOURNAL for each member of the Rhode Island Medical Society."

At the meeting of January 19, 1939, the Managing Editor reported to the Council that he had sent the following letter to the Publication Committee:—

"My resignation as Editor of the JOURNAL has now been in the hands of the Committee on Publication for considerably over a year. I understand that the reason that it has not been accepted is that the Committee has been unable to find anyone to continue the work. In my opinion the following are contributing causes to this condition:—

"1. The Rhode Island Medical Society refuses to give any financial support to the JOURNAL.

"2. The Society has no provision for secretarial work.

"3. Although the Committee on Publication is elected by the House of Delegates, the Council has transferred the financial control of the JOURNAL from the Committee on Publication to the Treasurer of the Society, an arrangement which makes efficient management of the JOURNAL impossible.

"I am continuing in the position of Managing Editor with the following stipulation:— that at my convenience and without further notification, I shall suspend publication of the JOURNAL. Before the date of suspension a notification will be sent to each name on the mailing list."

REPORT OF THE SOCIAL SECURITY COMMITTEE OF THE RHODE ISLAND MEDICAL SOCIETY.

Introduction

The first official communication that the American Medical Association received from the Interdepartmental Committee to Co-ordinate Health and Welfare Activities of the Federal Government was an address prepared by Miss Josephine Roche, Chairman of the Interdepartmental Committee, and delivered before the House of Delegates of the American Medical Association, at the San Francisco Session, June 14, 1938. This address was delivered at the invitation of the Board of Trustees of the American Medical Association, in the absence of Miss Roche, by Assistant Surgeon General Warren F. Draper of the United States Public Health Service, and himself a member of the House of Delegates.

The Interdepartmental Committee was created in August 1935, following the passage of the Social Security Act, and is composed of the Assistant Secretaries of the Treasury, Interior, Agriculture and Labor Departments, and the Chairman of the Social Security Board.

Technical Committees were set up for co-ordination of Federal and State agencies. The Technical Committee on Medical Care accepted the National Health Survey made by the Public Health Service, which provided an index of disabling illness on the basis of 800,000 families, including 2,800,000 individuals, and produced a report on "The Need for a National Health Program," which was submitted to the President of the United States.

The National Health Survey was made largely by W.P.A. workers over a period of six months under the supervision of the Public Health Service. The resulting statistics were based on a house-to-house canvass of 740,000 urban, and 36,000 rural families. Much of the reported illness and types of disease had no medical confirmation. The fact that the diagnosis and evaluation of reported disease was made without medical training would in itself make the survey of doubtful value.

At the same time the American Medical Association has been conducting an independent survey, through the co-operation of individual physicians, dentists, hospitals and other groups, under the direction of county medical societies. Although the Survey carried out by the Medical Societies is not

completed there is shown to be a marked difference in figures. For example, the census of the American Medical Association shows that only 2,000,000 people in the United States live more than thirty miles from a general hospital, whereas the National Health Survey gives the figure as 17,000,000.

Miss Roche's report states that the existence of grave and far-reaching needs is established and cites impressive figures indicating loss of time due to illness, lack of medical care in obstetrical cases, deaths from tuberculosis and other statistics.

The percentage of illness and lack of medical care is higher in the low income group, and an income of \$3,000 or over has been determined as the dividing line between families who can receive adequate medical attention, and those who may be deprived of necessary medical and allied services.

As a result of the work of the Technical Committee on Medical Care, a National Health Conference was called by the Interdepartmental Committee and met in Washington, D. C., July 18-20, 1938.

The Technical Committee summarized its studies of present health and medical services in the United States as follows:

1. Preventive health services for the nation as a whole are grossly insufficient.
2. Hospital and other institutional facilities are inadequate in many communities, especially in rural areas, and financial support for hospital care and professional services is both insufficient and precarious.
3. One-third of the population, including persons with or without income, is receiving inadequate or no medical service.
4. An even larger fraction of the population suffers from burdens created by illness.

To this Conference were invited a carefully selected group of some 150 individuals, most of whom were known because of their so-called liberal views toward medical care, including social and welfare workers, magazine editors, newspaper men and labor union representatives. Conspicuous by their absence were representatives of banking, investment, industry and manufacturing, who might have been interested in the financing of the vast expenditures involved. A small group of physicians representing the American Medical Association were invited. They were quite overwhelmed by the mass of hostile propaganda, and for all practical purposes, might better have stayed at home.

There was much emotional well wishing, and much confusion by the laity of the indigent with the low income groups. The physician was made to feel as a guilty conspirator to block justice and progress,—a selfish, narrow-minded individual having no ability to manage affairs of health.

The Committee submitted a program of five recommendations to meet the problems of health and medical services which will be discussed in detail a bit later.

Following the National Health Conference, a special session of the House of Delegates of the American Medical Association was called to meet in Chicago, September 16-17, 1938, to consider the national health program as submitted at the above Conference.

Report of the Rhode Island Committee

The following is the report of the Social Security Committee of the Rhode Island Medical Society, appointed by the President to consider the proposals of the National Health Conference. These proposals are as follows:

RECOMMENDATION I

Expansion of the Public Health Service

1. We agree with the Reference Committee of the House of Delegates of the American Medical Association in recommending the establishment of a Federal Department of Health with a secretary who shall be a doctor of medicine and a member of the President's cabinet.

2. The general principles outlined by the Technical Committee for the expansion of Public Health and Maternal and Child Health services are approved. The Rhode Island Medical Society definitely seeks to co-operate in developing efficient and economical ways and means of putting into effect this recommendation.

3. Any expenditures made for the expansion of public health and maternal and child health services should not include the treatment of disease except so far as this cannot be successfully accomplished through the private practitioner.

RECOMMENDATION II

Expansion of Hospital Facilities

Your Committee favors the expansion of general hospital facilities where such need exists. The hospital situation in Rhode Island would seem to indicate that there is need for providing some arrangement by which the indigent of the smaller towns

can use the existing hospitals in the State. If this is done we are of the opinion that existing facilities will be sufficient. Your Committee heartily approves the recommendation of the Technical Committee stressing the use of hospital facilities. The stability and efficiency of many existing church and voluntary hospitals could be assured by the payment to them of the cost of the necessary hospitalization of the medically indigent.

More research facilities are needed for mental cases which now occupy 50% of the hospital beds of the country.

Government statistics do not take into account the factor of medical progress which is constantly cutting down the period of hospitalization.

RECOMMENDATION III

Medical Care for the Medically Needy

Your Committee advocates recognition of the principle that the complete medical care of the indigent is a responsibility of the community and of the medical and allied professions, and that such care should be organized by local governmental units and supported by tax funds.

Since the indigent now constitute a large group in the population your Committee recognizes that the necessity for State aid for medical care may arise in poorer communities and the Federal government may need to provide funds when the State is unable to meet these emergencies.

Reports of the Bureau of the Census, of the U. S. Public Health Service and of life insurance companies show that great progress has been made in the United States in the reduction of morbidity and mortality among all classes of people. This reflects the good quality of medical care now provided. Your Committee wishes to see continued and improved the methods and practices which have brought us to this present high plane.

Your Committee wishes to see established well co-ordinated programs in the various states in the nation, for improvement of food, housing and the other environmental conditions which have the greatest influence on the health of our citizens. Your Committee wishes also to see established a definite and far-reaching public health program for the education and information of all the people in order that they may take advantage of the present medical service available in this country.

We believe that in Rhode Island at any rate the interests of the public will best be served by a mini-

mun amount of home and office care of the medically indigent, and generous contributions from tax funds for medical care at the hospitals. We believe that the medically indigent can best be cared for when hospital facilities are available when needed, as the private practitioner cannot be expected to bear the burden of carrying out expensive technical procedures.

In the face of the vanishing support of philanthropy, the medical profession as a whole will welcome the appropriation of funds to provide medical care for the medically needy, provided, first, that the public welfare administrative procedures are simplified and co-ordinated; and, second, that the provision of medical services is arranged by responsible local public officials in co-operation with the local medical profession and its allied groups.

Your Committee feels that in Rhode Island a system should be developed to meet the recommendation of the National Health Conference in conformity with its suggestion that "The role of the Federal government should be principally that of giving financial and technical aid to the states in their development of sound programs through procedures largely of their own choice."

A medically indigent person has been defined as one who is unable in his home through his own resources to provide medical, dental, nursing and hospital services and pharmaceutical needs without depriving himself of food, clothing and shelter as determined by the local health officer.

RECOMMENDATION IV

A General Program of Medical Care

We do not at present give any discussion about medical care for the whole people except to state that we agree with the Reference Committee in being unwilling to support any system of State care for the bulk of the population, or any system of compulsory health insurance.

RECOMMENDATION V

Insurance Against Loss of Wages During Sickness

This Committee approves of the report of the Reference Committee which reads as follows:

"Under Recommendation V on Insurance Against Loss of Wages During Sickness: In essence, the recommendation deals with compensation of loss of wages during sickness. Your Committee unreservedly endorses this principle, as it has distinct influence toward recovery and tends to reduce permanent disability. It is, however, in the

interest of good medical care that the attending physician be relieved of the duty of certification of illness and of recovery, which function should be performed by a qualified medical employee of the disbursing agency."

As has been mentioned in this report we recommend that the Rhode Island Medical Society adopt the policy favoring administration of plans for medical care by local communities and by states with a minimum of Federal control.

Your Committee feels that any plans for medical care in Rhode Island should be made with the active co-operation and approval of the Rhode Island Medical Society.

Your Committee further recommends:

1. That if accepted this report be printed or mimeographed and mailed to every doctor in the State.
2. That plans be made for discussion of this subject in the District Medical Societies.

The above report is unanimously adopted by the Committee.

Respectfully submitted,

ALEX M. BURGESS, Providence
WILLIAM P. BUFFUM, Providence
RALPH DI LEONE, Providence
JOHN F. KENNEY, Pawtucket
GUYON G. DUPRE, Woonsocket
JOHN W. HELFRICH, Westerly
SAMUEL ADELSON, Newport
GEORGE L. YOUNG, East Greenwich
ROLAND HAMMOND, Providence,

Chairman.

Comment

The Committee of seven appointed at the special session of the House of Delegates held on September 17th to meet with Federal representatives relative to the proposed national health program, assembled in Washington October 31, 1938.

The action of the House of Delegates was fully discussed before the two Committees, and the discussion was confined largely to principles involved.

Recommendation I on Expansion of Public Health Service elicited but little discussion. There was no opposition to the position taken by the Medical Committee that the treatment of disease should not be included in this category except where it cannot be carried out by the general practitioner.

Recommendation II on Expansion of Hospital Facilities brought out the discrepancies between the statistics assembled by the Technical Committee and those gathered by the American Medical Asso-

ciation. No final solution was reached but it was agreed by all that standards compatible with good service, both hospital and professional, should be maintained, and that these would vary with location, character and size of service to be rendered. It was agreed by all that existing hospitals should be utilized, and that additional hospitals should be built solely on a basis of need. The suggestion of 4.5 hospital beds per thousand of population as representing a ratio of hospital needs was not accepted by the Medical Committee.

Diagnostic Centres are planned for rural communities to cost \$30,000 each, and to include provision for treatment as well.

Under Recommendation III on Medical Care for the Medically Needy, the Medical Committee called attention to the many plans that are being tried out by the component units of the American Medical Association. The Technical Committee regards the health departments as the central agency around which such plans should be developed. It was pointed out that under the present system of practice needy patients do not avail themselves of services offered, and that further provision of services should be arranged by responsible local public officials in co-operation with the local medical profession and its allied groups.

Recommendation IV on a General Program of Medical Care brought out the controversial principles between the two Committees, regarding sickness insurance. The Medical Committee favored the voluntary and the Technical Committee the compulsory type.

Comparing this form of insurance to that already prevailing under Workmen's Compensation Acts, the question was propounded as to whether there is a difference between acceptance by doctors of pay for service from compensation boards, and acceptance of pay by them from a governmental, tax supported agency with free choice of physician allowed. The discussion resulted in a deadlock.

Recommendation V on Insurance Against Loss of Wages during sickness occasioned little or no discussion.

The Interdepartmental Committee is to call conferences with representatives of the American Public Health, Dental, Hospital and Nursing Associations, and following these conferences, another meeting with the Committee from the American Medical Association was suggested in the hope that differences in viewpoint might be ironed out before the final report of the Interdepartmental Committee is submitted to the President, and later to Congress when its recommendations may be embodied in proposed legislation.

PROVIDENCE MEDICAL ASSOCIATION

Minutes of the February Meeting

The regular meeting of the Providence Medical Association was called to order by the President, Dr. Harry C. Messinger, on Monday, February 6, 1939, at 8:35 P. M. The minutes of the last meeting were read and approved. The Secretary reported for the Standing Committee as follows:

1. That a motion had been passed that the Standing Committee recommend that the President be empowered to appoint a Committee to study Voluntary Health Insurance and allied matters.

2. That a motion was passed that a Committee be appointed to study the various phases of telephone service as used by the membership and that the Executive Secretary be made a member of that Committee.

3. That a motion was passed that the President be empowered to appoint a Committee to study Group Health and Accident Insurance for Physicians.

The report of the Standing Committee was accepted.

Dr. Philip Batchelder presented the report of the Committee on Tuberculosis and Silicosis, stating prior to the reading of same that it was not a final report but rather a preliminary survey with recommendations deemed advisable at this time. Dr. C. S. Westcott moved that the report be accepted. The motion was seconded and passed. Dr. Langdon moved that the Recommendations made in the report be adopted. The Motion was seconded and passed.

The President reported that the Committee of Dr. Michael Milan and Dr. Thomas Grzebien had filed with the Secretary a prepared obituary and tribute to Dr. Richard Boucher which was available to any member of the Association for reading.

The name of Doctor Himon Miller was submitted for election to membership. Dr. Muncy moved that Doctor Miller be elected. Motion was seconded and passed unanimously.

President Messinger announced the appointment of the following Committee Appointments: To prepare an obituary of Dr. George Crooker: Dr. John M. Peters and Dr. Bertram Buxton. To prepare an obituary of Dr. Edward Pierce: Dr. Jesse Mowry and Dr. John E. Donley. Committee to Study Group Health and Accident Insurance for Physicians: Dr. Robert G. Murphy, (Chairman),

Dr. Emanuel W. Benjamin, Dr. James H. Cox. Committee to Study Telephone Service as Provided: Dr. John G. Walsh, (Chairman), Dr. James H. Fagan, Dr. Walter S. Jones, Dr. Nathan S. Rakatansky, Mr. John E. Farrell. To fill a vacancy on the Legislative Committee caused by the resignation of Dr. Roland Hammond: Dr. E. V. Conrad.

Dr. William Muncy moved that the President be empowered to appoint a Committee to study the Problem of Voluntary Health Insurance and Allied Matters. The motion was seconded and passed. President Messinger announced the appointment of Dr. Alex M. Burgess as Chairman for this Committee on Voluntary Health Insurance and stated that the complete list of appointments to the Committee would be announced at a subsequent date. The President reported that information regarding railroad and hotel expenses for members planning to attend the Convention of the College of Physicians in New Orleans March 27-31 would be available through the office of the Executive Secretary.

The business meeting being concluded, the President introduced as the first guest speaker of the evening Mr. Joseph Broderick, Collector of Internal Revenue for the Providence District. Mr. Broderick spoke briefly regarding the Income Tax regulations as applied to physicians, and then introduced Mr. John O'Connell, Chief of the Income Tax Division, who outlined the main points to be considered in filing of tax returns by physicians and then answered questions proposed by members.

Doctor Gordon M. Morrison of Boston, next presented for discussion the topic "Therapeutic Applications of Occupational Therapy," illustrating his talk by means of a motion picture illustrating rehabilitation work among those handicapped. Discussion was opened by Dr. Burton, who was followed by Dr. Fitzpatrick, Dr. Stone, and Dr. Horan. Dr. Morrison closed the discussion and introduced Miss Blodgett, who is engaged in Occupational Therapy at Faulkner Hospital in Boston.

Dr. Russell S. Bray concluded the scientific program with a splendid discussion of "Gastroscopy and Clinical Medicine," showing some unusual colored plates to illustrate his topic. Dr. S. Morein and Dr. Elihu Wing discussed the presentation of the topic.

The meeting was adjourned at 11 P. M. Attendance 175. Collation was served.

Respectfully submitted,

HERMAN A. LAWSON, M.D., *Secretary*.

Report of the Committee on Tuberculosis and Silicosis

In presenting this report of the Committee on Tuberculosis and Silicosis to the Providence Medical Association we wish to stress that our recommendations concern only our Association and our local problems. Many of the factors in the successful handling of tuberculosis are, of necessity, statewide in scope, and it might be profitable for a committee from the State Medical Society to investigate some of the larger aspects of the situation. Until such time, there are several local phases which we feel could be improved, and, when and if the State Society sees fit to act, our program could be easily modified to meet new conditions.

As it is through the practicing physician that most of the new cases of tuberculosis are found it is essential at the onset that his interest and co-operation be secured. All physicians know the seriousness of tuberculosis and of course are interested in anything which would decrease or eradicate the disease. To enliven this more or less passive interest into an active individual effort would very certainly show results. The definite increase in interest which was shown following the recent talk before the Association by Dr. David R. Lyman points to one way in which knowledge and interest may be increased. Occasional speakers who could inform the Association of the more recent advances in the diagnosis and treatment of tuberculosis would increase the zeal for attacking the problem.

The Rhode Island Tuberculosis Association has much information material available for both physicians and the public and would be only too happy to assist in its distribution. Small pamphlets or mimeographed messages sent out with the monthly meeting notices would help keep up the good work between the stimulations of formal addresses before the Association.

It is felt that closer relations between our state sanatorium and the profession would be of distinct benefit, although that is more of a state problem. It is many years since a meeting of the medical society has been held at Wallum Lake. Many physicians do not know at first hand of the facilities available for treatment of their patients. Other desirable details such as follow-up letters from the sanatorium reporting progress at regular intervals, in addition to the present notification on admission and discharge, could be worked out.

Mr. Willis E. Chandler, Executive Secretary of the Rhode Island Tuberculosis Association, has offered his services and those of his organization for any lay or professional program of publicity and education which the Association approves. He has assured us that he would much prefer to have the initiative come from the medical society and that once it is secured he and his association have large amounts of suitable literature which could be distributed under the direction of our Association. He also can obtain the services of a publicity manager for an occasional intensive campaign if that is desired. Such a publicity director could correlate the activity of the different agencies interested in tuberculosis, by getting their publicity into the newspapers and over the radio. A first class man working in this way would do much to make the city conscious of the problem and of the available means and methods for the control of tuberculosis.

We believe that publicity sharply pointed at the critical parts of the program is much more valuable than general publicity on the dangers and prevalence of tuberculosis. In fact, it is the opinion of some that the fear side of the education program has already been stressed too much in the past. Especial emphasis should be laid on the importance of the examination of all contacts and of the age group of 15 to 25 years, and the fact that no examination of the chest is really complete without a properly executed chest X-ray study.

Your Committee takes the stand of recommending X-ray examinations of the chest of contact cases and others, including a tuberculin test where desired. We feel that an X-ray examination in adults is of great importance, since the physical examination may not show abnormal findings in an early case. The objection of expense may be raised, but of what advantage is it to save a few hundred dollars on negative chest examinations only to miss an early case which, when late, will cost several thousands of dollars to cure.

One should not imply from the foregoing that we disapprove of the tuberculin test, but merely that the apparent obvious economy may really be uneconomical. The facts derived from an X-ray examination of the chest are more definite. From the point of view of the educational program, it would appear to be much simpler to advise a single procedure. We believe that our suggestion is the best for this particular purpose, but we can imagine situations in which a tuberculin test would be desirable.

The whole aim of the program is to discover the incipient or early case, thus saving the patient time and suffering, and money for the patient and the State. Those patients without funds would have to be examined by some public agency, those who could afford to pay would go to a private roentgenologist. All of the roentgenologists of Providence have agreed to charge a minimum fee, when necessary, in such cases. An incidental but none the less valuable feature of the chest X-ray examination would be the discovery of non-tuberculous lung conditions and some cases of heart disease which otherwise might pass unnoticed.

In view of the fact that it is recognized that the age group of 15-25 years furnishes the greatest number of new and early cases of tuberculosis, we advocate an effort to have examined and X-rayed as many of this group as possible. It is in this period of from 15-25 years that most individuals start gainful employment. If a plan could be adopted which would provide for a physical examination and X-ray of the chest before employment of all persons under 30 years of age, we feel sure that many early cases would be discovered.

We therefore advocate a plan by which every influence is exerted to bring about such examination at the time of first employment in industry, city, state and federal departments, schools, and restaurant and domestic services. Students of colleges and professional and trade schools should also be included. In those industries where silicosis is a potential hazard, chest X-ray examinations should be made before employment at any age.

For the early discovery of tuberculosis, at least three distinct methods of approach would have to be used to induce the individuals in the different fields to have these examinations made. In all there would have to be an extensive educational program.

Nursemaids and other domestic help could be certified by the medical association as being free from disease after having passed a standard physical examination including laboratory tests and chest X-ray examination. Employment services and employers could be taught the value of the certification. The employees would gradually see the advantages in gaining and holding employment.

A similar procedure would hold for food handlers, and in addition, when all its employees had been thus examined and passed, a special certificate could be given by the medical association to the restaurant for public display.

In the case of governmental employees, the group comprising school teachers is particularly important, as they come in close daily contact with young children. The Providence school department has already made a ruling that all teachers must be examined before starting work. We hope that their excellent example will be followed by other departments.

For general industry still other arguments would have to be used. Many employers are already somewhat public health-minded. Further effort would not have to be great to convince them of the desirability of hiring physically sound workers at the start. Another line of approach would be from the point of view of protection of the fellow workers.

An annual X-ray examination for domestic servants, food handlers, and school teachers would be very desirable, but it would probably be well to postpone consideration of this feature until the results of the initial examinations had been collected and studied.

Because of the extended time necessary for the care of the tuberculous, much of the expense of diagnosis, treatment, and rehabilitation has to be borne by public funds. Of these three factors in the control of this disease, that of diagnosis is the least involved with governmental control. It is partly for this reason that it was decided to largely limit our suggestions to the first factor.

While the Providence City Health Department has been limited by lack of funds and other matters in doing much along the lines of treatment, rehabilitation, and study, it is understood that plans are under way to have the department take a more active part in the program. For example, if the proposed amendment to the law regarding the reporting of tuberculosis is passed, the City Health department can be of considerable help to the practicing physicians in identifying and following up contacts. They also hope to have the services of public health nurses who will aid in the epidemiological investigation of the disease and gather data for study.

As mentioned above, there are many of the larger aspects of the problem of tuberculosis which have not been touched, partly because they involve statewide changes and partly because we believe effort should be confined, for the present at least, to more restricted and specific problems, i.e., (1) the chest X-ray examination of contacts, and (2) the examination of workers at the time of first employment.

We make the following recommendations and urge their adoption:

1. That the effort be made to have at least one paper a year read by a guest speaker before the Association on the subject of tuberculosis.
2. That the aid of interested agencies be secured to assist us in arousing further interest among the profession, and in carrying out a lay program of education.
3. That the main theme of the publicity be the examination of individuals *under thirty* years of age and of all contacts.
4. That the Association approve the policy of routine chest X-ray examinations for the above groups.
5. That the Association set up a medical certification committee, similar to the Milk Commission, which would work out the details of certification of certain groups as mentioned in the body of this report.

Respectfully submitted,

PHILIP BATCHELDER, M.D., *Chairman*

WILLIAM P. BUFFUM, M.D.

FRANCIS H. CHAFEE, M.D.

JOSEPH SMITH, M.D.

UBALDO E. ZAMBARANO, M.D.

Rhode Island Hospital

Dr. Ernest Gaillard, Jr., of Louisville, Kentucky, after spending one month at the Lying-In Hospital as an intern, started a two years' internship at Rhode Island Hospital on January 15th, 1939. Dr. Gaillard is a graduate of University of Kentucky and University of Louisville Medical School.

On February 1st, Dr. Lee Sannella began a year's internship at the Eye and Ear Hospital in Newark, N. J. Dr. Sannella also expects to attend lectures and classes at the New York Eye and Ear Hospital.

On February 15th, Dr. Charles B. Ceppi of Syracuse, N. Y., a graduate of Princeton College, and Syracuse Medical School, began a two years' internship at the Rhode Island Hospital. Dr. Ceppi did substitute intern work at Syracuse Memorial Hospital for eight weeks, St. Joseph's Hospital, six weeks, Syracuse General Hospital, three months and Providence Lying-In for one month.

On January 25th, Dr. Lawrence Minish completed his internship at the Rhode Island Hospital.

OBITUARY

JOHN FRANCIS McCUSKER, M.D.

Dr. John Francis McCusker died of cerebral hemorrhage on August 27, 1938. He was born in Providence, the son of Thomas and of Honor (Keough) McCusker, on November 19, 1865. He was graduated from the English department of the Providence High School in 1883. He then entered Manhattan College, New York, from which he received the degree of B.S. and at the same time the gold medal for mathematics. From Manhattan he received the degree of M.S. in 1892, and LL.D., *honoris causa*, in 1922. Deciding to become a physician, he entered the College of Physicians and Surgeons of Columbia University and obtained his M.D. in 1889.

From 1889-90 he was house officer at the Rhode Island Hospital and externe surgeon 1890-94. He was a member of the staffs of the Providence Lying-In Hospital, 1892; the Metropolitan Eye, Ear, Nose and Throat Hospital, New York, 1895; The Massachusetts Eye and Ear Infirmary, 1896-97. From 1891 to 1894 he was attending physician to St. Joseph's Hospital and for a time served as Secretary of the St. Joseph's Hospital Staff Association. He was a member of the consulting staff of the Charles V. Chapin Hospital and of the courtesy staff of the Rhode Island Hospital and for some years was attending physician, United States Public Health Service.

On September 21, 1908, Doctor McCusker married Miss Mary Florence Rafter of Damariscotta, Maine, who predeceased him.

He was a member of the Providence Medical Association, the Rhode Island Medical Society, the Alumni Association, the Massachusetts Eye and Ear Infirmary, and the American College of Surgeons. For twenty-five years he was a member of the Providence Lodge, No. 14, the Benevolent and Protective Order of Elks.

Although in the early years of his medical career, Dr. McCusker was engaged in the practice of general medicine, he attained his greatest distinction as one of our best-known specialists in diseases of the eye, ear, nose and throat. For more than forty years he was busy in the practice of his specialty. He was revered by his patients and his colleagues as one whose technical skill was as great as his knowledge was comprehensive. Naturally a pleasant companion, he spiced his conversation with many a sally of wit and humor. He was a great

lover of books; his reading was omnivorous. He was, in truth, a splendid example of the humanist physician whose reticence too frequently conceals the stores of his learning. While reading he was accustomed to write critical notes upon the margins of the pages. Those who read his notes found them often times more interesting than the text. Through a long life he made many friends who cherish his memory as a sincere physician and a real scholar in medicine.

He is survived by his daughter, Miss Honor McCusker, a member of the staff of the Boston Public Library in the department of rare books.

JOHN P. COONEY, M.D.

JOHN E. DONLEY, M.D.

RECENT BOOKS

SURGICAL TREATMENT OF HAND AND FOREARM INFECTIONS.
By A. C. J. Brickel, M.D. pp. 300, With 166 Text Illustrations and 35 Plates, Including 10 in Color. Cloth, \$7.50, The C. V. Mosby Company, St. Louis, 1939.

In the first 100 pages of this excellent work there is a description of the anatomical structure of the hand and forearm, based on original dissections and illustrated with plates of which many are in color. The synovial sheaths and bursae are demonstrated by x-ray plates made after the injection of radiopaque material by an original method. After a discussion of general principles the special surgery of infections of the hand and forearm is exhaustively treated. Finally the influence of specific infections and of general diseases is considered. The author, the artists, and the printers have collaborated to make this book a worthy successor to Kanavel's monumental work on the subject

CLINICAL LABORATORY METHODS AND DIAGNOSIS. By R. B. H. Gradwohl, M.D. Second edition. Price \$12.50. Pp. 1500, with 492 illustrations and 44 color plates. St. Louis; The C. V. Mosby Co., 1938.

This comprehensive work on clinical laboratory procedures is a valuable reference for the professional laboratory man, and parts of the work are of value to the clinician. The chapters on Parasitology and Toxicology are particularly valuable to the practitioner who has only occasional need for such reference. Although the technical procedures included in the chapters on blood chemistry do not include the most recent determinations and do not sufficiently cover the clinical application for these determinations, the book is one that fills a gap in the practitioner's library. Technically, the book is unusually good and will stand hard usage. Illustrations in color and in black and white are of good quality and are well chosen.

CECIL C. DUSTIN, M.D.